World Cultural Psychiatry Research Review
OFFICIAL JOURNAL OF
WORLD ASSOCIATION OF CULTURAL PSYCHIATRY

Original Paper

Characteristics of first and second generation Asian mental health patients in Bolton, UK

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Abstract. ***Objective****: To determine whether significant and clinically relevant differences exist between 1st and 2nd generation Asian ethnic groups who use mental health services in Bolton, UK. The primary aim of this study was to elucidate disparities in socio-demographic characteristics and patterns in mental health care utilization in a secondary care setting.* ***Method****: All Asian patients over 18 years were selected from the open referral list in the Bolton Mental Health Unit. We obtained all relevant data from retrospective case note analysis, over a 2-year period.* ***Results****: Data was obtained from 216 patients. Statistically significant inter-generational differences were noted on a diverse range of demographic variables, and there were significant and fundamental differences pertaining to the utilization of mental health care services in a variety of clinical settings. More 2nd generation compared to the 1st generation Asians had psychological contacts (12.7% vs. 4.3%; p=0.026) and primary care contacts (10.9% vs. 2.5%; p=0.01). The 1st generation group was more likely to be married (p=0.02) and unemployed (p=0.036) at the time of the study.* ***Conclusions****: Inter-generational differences within ethnic minority patient populations, and associated utilization and engagement with mental health services should be fundamental considerations, in the operational planning and delivery of psychiatric services in the UK. Such pivotal considerations may lead to increased patient autonomy, empowerment and a more favorable service user experience. This could have a profound impact on treatment response and prognosis by reducing barriers to access of appropriate care and support from mental health services in the UK.*

Keywords: Asian, ethnic, mental, health, service, clinical, demographic.

WCPRR December 2011: 95-101. **© 2011 WACP**
ISSN: 1932-6270

INTRODUCTION The provision of mental health services to people of South Asian origin and their experiences of using mental health services have been the subject of interest for many decades (Sashidharan, 2003). Although the need for culturally sensitive care is acknowledged within policy and service provision, the services currently available are far from adequate. There are differences in access to care and treatment and in the ways people are treated within services and within their own communities (Sashidharan, 2003).

There has been considerable focus on various aspects of mental health service provision to ethnic minorities in comparison with the general population in the UK (Department of Health, 2005). There may be inter-generational differences in health status in minority ethnic groups. For example, in some Black and minority ethnic groups, rates of ill health (such as cardiovascular disease) are worse among those born in the UK than in first generation migrants (Parliamentary Office of Science and Technology, 2007).

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Received April 16, 2011. Accepted November 15, 2011.

In this report, the term 'South Asian' refers to people of Indian, Pakistani and Bangladeshi origin. There are vast national, regional, cultural, religious, linguistic and political differences between the communities that are often studied under the term 'Asian'. The term has often been criticised as misleading because it assumes homogeneity (Bhopal, 2004).

Several studies have explored the prevalence of mental health problems in South Asian communities. The findings of these studies have often been contradictory and inconclusive (Anand & Cochrane, 2005; Hussain & Cochrane, 2004). In one such study on depression among Asian women it was found that results were different when subgroups were studied separately instead of looking at South Asian communities as one homogenous group (Hussain & Cochrane, 2004). It is acknowledged that more research is needed in this area (Sashidharan, 2003), and that the monitoring of ethnic mental health issues has been poor (Commission for Healthcare Audit and Inspection, 2005). This is supported by the Acheson Inquiry recommendation that needs of ethnic minority groups be specifically considered in planning and providing healthcare (Acheson, 1998).

The literature on patient characteristics and patterns of service utilisation across 1st and 2nd generation Asians is limited. Coid *et al* (2008) recently looked at generational differences with specific focus on 1st episode psychosis. They found that raised incidence of both non-affective and affective psychoses were found for all of the black and minority ethnic subgroups compared with white British individuals. Only first, rather than second-generation Asian immigrants, appeared to be at elevated risk for non-affective psychoses. Asian women but not men of both generations were at increased risk for psychoses compared with white British individuals. Another study showed that 2nd generation immigrants of South Asian origin did not have higher levels of psychological symptoms than 1st generation immigrants (Furnham & Shiekh, 1993). One may hypothesise that 1st generation Asians would have more difficulty in accessing/utilising services, due to language, communication and cultural issues.

METHOD Bolton is the largest town in England, located in the northwestern region. The mid 2009 estimate for the population of Bolton is 265,000 (Source: www.statistics.gov.uk). The largest of Bolton's minority groups is that of Indian background. With 15,884 people, 6.1% of the Borough's population, this is the largest such community in North West England. The national average for England and Wales for the Indian population is 2%). Bolton's population of Pakistani background numbered 6,487 people in 2001, 2.5% of the Borough's population (compared with the national average of 1.4%). This makes it the 6th largest such community in North West England. None of the other minority ethnic groups exceeds 1% of the Borough's population. Bolton's White population consists of 232,366 people or 89% of the total (Bolton Council, 2008).

Based on Bolton's ethnic makeup, an Asian Mental Health service was established at Royal Bolton Hospital in 2005 to help overcome possible barriers to service provision, due to culture, language or religion. The service operates on the basis of the Kirmayer model in Canada (Kirmayer *et al*, 2003), utilising a culturally competent team, which provides input to the team caring for the service user. The service covered both inpatients and patients in the community.

Data was collected on all patients of Asian ethnicity above the age of 18 years who were on the active patient list at Royal Bolton Hospital in 2007. The data included demographic, clinical and service use details and covered a period of 24 months from 2005-2007.

The data collection was carried out retrospectively by inspecting the patients' electronic clinical records. Each patient's ethnicity, age, gender, place of birth, preferred language, religion, employment and marital status were obtained. Ethnic group was classified using the framework provided by the 2001 Census (Office for National Statistics, 2001). Ethnic origin was recorded on the basis of self reporting. South Asian patients born outside of the UK were classified as 1st generation Asians irrespective of the age they migrated to the UK and of their preferred language. Patients of South Asian ethnicity with place of birth as UK were classified as 2nd generation Asians. Diagnoses were made clinically and coded according to ICD-10, Chapter V (WHO, 1993). Broad diagnostic categories were used by grouping together the psychotic, mood and anxiety disorders as indicated in the electronic records.

Patients' level of care was established on the basis of Care Programme Approach records. Care Programme Approach (CPA) is a United Kingdom system of delivering community services to patients with mental illness; patients under enhanced CPA are typically assigned a care coordinator to regularly review their care plans. In order to identify service users who attended most of their outpatient appointments an arbitrary measure of attendance rates of more than 60% was used; number of inpatient episodes was also recorded. In addition contacts with services such as primary care, crisis intervention, assertive outreach, and psychology were recorded. Data was collected on the number of serious and non-serious incidents and on the number of patients committed involuntarily under the Mental Health Act.

Data were analyzed using SPSS (Version 16). Main comparisons were between 1st and 2nd generation patients. A *p* value of less than 0.05 was interpreted as showing a significant difference existed, when comparing the 1st generation with the 2nd generation groups and levels of significance were tested using the χ square statistic.

RESULTS

Sample

Patient Characteristics There were 161 patients who were designated as 1st generation and 55 classified as 2nd generation. When 1st and 2nd generation patients were compared we found that the 1st generation group was more likely to be older, married, and unemployed at the time of the study and of Indian origin and Muslim faith (see **Table 1**). The data regarding divorced or widowed status was not available from the records.

Table 1 Demographics data

Characteristics	1st generation Asians (N=161)		2nd generation Asians (N=55)		Total (N=216)		χ squared *p* value
	N	%	N	%	N	%	
Age (mean)	46.4		35.4				N/A
Range (years)	(21-74)		(27-54)				
Gender							$\chi^2 = 4.122$
Male	74	45.9	34	68	108	50	df= 1
Female	87	54.1	21	32	108	50	$p = 0.042$*
Marital status							$\chi^2 = 9.700$
Single	50	31.0	30	54.5	80	37	df= 1
Married	111	69.0	25	45.5	136	63	$p = 0.002$*
Ethnicity							$\chi^2 = 64.1$; df= 2
British Indian	101	62.7	25	45.4	126	58.3	$p = 0.00$
British Pakistani	59	36.6	30	54.6	89	41.2	
Other	1	0.07	0	0	1	0.5	$\chi^2 = 5.268$; df= 1
							$p = 0.022$*
Religion							$\chi^2 = 4.335$
Muslim	130	80.7	51	92.7	181	83.8	df= 1
Hindu	31	19.3	4	7.3	35	16.2	$p = 0.037$*
Employment							$\chi^2 = 4.402$
Employed	13	8.1	10	18.2	23	10.6	df= 1
Unemployed	148	91.9	45	78.8	193	89.4	$p = 0.036$*

* Statistically significant result

Clinical Characteristics Over 40% of those who were in contact with services had a diagnosis of psychotic disorder. There was a trend toward anxiety disorder being more common amongst 2nd generation South Asians (40% compared to 29%) and mood disorders being more prevalent amongst 1st generation (29% compared to 16%). The attendance to outpatients clinic was greater in the 1st generation group. However the 2nd generation group was more likely to be managed under enhanced CPA and had more contacts with Psychology and Primary care services. The results are depicted in **Table 2**.

Table 2 Clinical characteristics

Characteristics	1st generation Asians (N=161)		2nd generation Asians (N=55)		Total (N=216)		χ squared *p* value
	N	%	N	%	N	%	
Diagnosis							
Psychotic d/o	68	42.2	24	43.6	92	42.6	$\chi^2 = 4.322$
Mood d/o	47	29.1	9	16.3	56	25.9	df= 2
Anxiety /other	46	28.7	22	40.1	68	32.5	*p*= 0.115
CPA level							$\chi^2 = 4.665$
Standard	100	62.1	25	45.4	125	57.9	df= 1
Enhanced	61	37.9	30	54.6	91	42.1	*p*= 0.031*****
Outpatient attendance >60%	152	94.4	42	76.4	194	89.9	$\chi^2 = 14.595$; df= 1 *p*= 0.000*****
Inpatient episodes	41	25.4	15	27.3	56	25.9	$\chi^2 = 0.70$; df= 1 *p*= 0.792
Crisis contact	29	18.0	13	23.6	42	19.4	$\chi^2 = 0.828$; df= 1 *p*= 0.363
Assertive outreach	2	1.2	3	5.4	5	2.3	$\chi^2 = 3.217$; df= 1 *p*= 0.073
Psychology contacts	7	4.3	7	12.7	14	8.7	$\chi^2 = 4.749$; df= 1 *p*= 0.029*****
Primary care contacts	4	2.5	6	10.9	10	4.6	$\chi^2 = 6.590$; df= 1 *p*= 0.01*****
Sections (committed)	18	11.1	8	14.5	26	12	$\chi^2 = 0.439$; df= 1 *p*= 0.508
Non serious incidents	4	2	2	3.6	6	2.7	$\chi^2 = 0.201$; df= 1 *p*= 0.654
Serious incidents	4	2	2	3.6	6	2.7	$\chi^2 = 0.201$; df= 1 *p*= 0.654

***** Statistically significant result

DISCUSSION Our findings suggest that with regards to 1st and 2nd generations the Asian ethnic population should not be considered or studied as a homogenous group and interpretations should not be generalized.

The results indicate that the mean age of patients was higher in the 1st generation group, as would be expected. We postulate the reasons which may explain this difference in terms of the inclusion of an elderly population in the sampling process. One may hypothesise that the stigma of mental illness may mean the 1st generation Asians seek help from psychiatry services later than those who are younger. Some of this population could be accounted for by 1st generation Asians who migrated to the UK through marriage.

Possibly, due to the cultural and social consequences of marrying outside of the community which include isolation and being extricated from the wider community, there are more 2nd generation Asians who are single.

The migration patterns over the years could explain the significant differences in ethnicity, religion and employment status in the two generation groups. Large-scale migration to Bolton began to be apparent in the early 1960s. Settlers who were mostly unskilled labourers from rural areas found work in manufacturing, engineering and catering industries continued to arrive at a steady rate throughout the 1960s from Gujarat, the Punjab and from Kashmir until the 1971 Immigration Act ended the immigration into this country (Source: www.movinghere.org.uk).

The results indicate a higher number of unemployed 1st generation Asians, which may be accounted for by the inclusion of elderly patient population in the first generation sample, and the decline of the Lancashire textile industry in the 1960's which provided a source of employment for a significant proportion of economic migrants from the Asian diaspora.

This premise may also serve to provide a possible explanation for the greater proportion of 2nd generation Asians who had psychology contacts. One may postulate that 2nd generation Asians were

more fluent and proficient in English and faced less cultural stigmatisation, in terms of seeking psychology input. Indeed one may argue they were more psychologically minded. It is a widely accepted notion that poor fluency in English limits the prospects of accessing and responding to talking treatments such as Cognitive Behavioural Therapy. Furthermore assessing clinicians would undoubtedly gain a clearer understanding of an individual's symptomatology and nature of their mental health problems in patients who are not restricted by language constraints and hence are more likely to be referred for indicated psychological interventions.

It may well be the case that certain patients in the 1st generation were suitable for accessing indicated psychological treatments, but due to language barriers were not able to express their symptoms accurately and hence were not referred for these interventions. It would be prudent to consider the notion that the hierarchical structure of Asian families could possibly lead to the 1st generation patients being more reticent and guarded about symptoms compared to 2nd generation Asians.

The study indicated that a greater proportion of 2nd generation Asians had their cases managed under the provisions of the enhanced CPA process. This would lend weight to the argument that this group had more complex, severe and enduring mental health needs. However conversely it must be noted that the results did not indicate statistically significant differences in the proportion of inpatient episodes, assertive outreach involvement or crisis contacts, although we didn't control for diagnosis.

It is very interesting to note that there were no statistically significant differences in the presence of psychotic and other major mental disorders between the two groups.

2nd generation Asians did demonstrate lower outpatient attendance rates and were more likely to access other interventions such as psychology.

It is difficult to opine on the reasons why the results demonstrated that 2nd generation patients had lower outpatient attendance rates, yet were more likely to engage with psychology services. Reasons pertaining to language barriers as described above, and risk do not adequately explain this finding, as if this were the case, the results would indicate that 2nd generation Asians were more likely to present to a variety of services.

One possible explanation for this finding may arise from the fact that a greater proportion of 2nd generation Asian patients were managed under the provisions of the enhanced CPA process, and hence by virtue of having an assigned and designated care coordinator in the community, may have reduced the patient's perceived necessity to attend outpatient clinics.

Younger age of onset if undetected and being single has been shown to be negative prognostic factors for mental health patients (Smith & Blackwood, 2004; Nyer *et al*, 2010). These demographic characteristics could account for the higher proportion of 2nd generation Asians being managed under enhanced levels of the Care Programme Approach.

LIMITATIONS The data was collected in one region only and the findings would need to be replicated across other such regions to establish national trends. The diagnostic groups were broad and clinical and the demographic information was as provided by patients. With regards to service utilization, data would have to interpreted with caution i.e. inpatient episodes and other such variables may have occurred in the same patients. Another limitation was the source of data used for the study. Using hospital records means the data used is only as good as the data inputted by the author originally. Administrative errors may have occurred during this process that would bias the results. These limitations impact upon the generalisability and validity of conclusions extrapolated and inferences drawn from the statistical analysis of the results.

The service utilization data revealed interesting differences in crisis resolution contacts, assertive outreach involvement and inpatient episodes, however these results were not statistically significant and therefore limit the ability to draw robust conclusions.

The diagnostic groups were broad and did not include categories such as personality disorder. There is limited research on the prevalence of personality disorder amongst ethnic minorities in general. This remains an area for further research and investigation.

Furthermore whilst previous studies have been limited in that results have been homogenised across groups (Hussain & Cochrane, 2004), it would be prudent to differentiate the 1st and 2nd generation

population samples into further subgroups, such as gender and religion, particularly given the contrasting societal roles and expectations placed upon women that can be seen across different cultures.

A further limitation arises from the data analysis, in that age alone could be a significant factor in accounting for differences observed between first and second generation Asians. Theoretical models, drawing upon linguistic and cultural differences between the two groups would be more robust and valid, if age was a controlled factor. Furthermore it would be prudent to undertake further statistical analyses of the data included in Table 2 of this paper, by undertaking a multivariate analysis to establish if the clinical characteristics such as age, ethnicity and sex etc are varied by factors other than generation.

The study did not ascertain the prevalence of illicit substance abuse and dependence as a co-morbid diagnostic entity. Data comparing the rates of substance misuse between the two groups may have led to important findings in terms of accounting for disparities in level of engagement and CPA processes. Increasing levels of alcohol use among 'second generation' migrant populations has been noted (Orford *et al*, 2004). This remains yet another area for further research and investigation.

CONCLUSIONS

There is a need for more studies in relation to mental health and ethnicity. Further such studies over other regions in the UK would be needed for the results to be generalized, but this study highlights that due importance should be given to the heterogeneity within ethnic minority populations in research and in service development.

ACKNOWLEDGEMENTS

We would like to thank Professor Sashidaran for his thorough review, comments and revisions of the article.

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